emergency departments or acute admissions. We analysed patients who were admitted to the acute surgical unit over a defined period, with respect to appropriateness of admission and possible alternatives.
Methods: Prospective data were collected over 28 days, (February–July 2014). Admissions were categorised as 'appropriate' (needed 'immediate admission', 'daytime review' or 'urgent surgical outpatient clinic') or 'inappropriate' ('needed routine outpatient clinic', 'no surgical issue' or 'no acute health problem') by the Consultant or senior trainee on call.
Results: There were 340 acute admissions in the data group, 270 in General Surgery, 51 in Urology and 19 in Vascular Surgery. Overall, 79.7% were considered appropriate (51.8% for immediate admission, 24.7% for daytime review and 3.2% for urgent clinic). 107 admissions (31.5%) were overnight. Of these, 54.2% were considered entirely appropriate. A further 31.8% needed urgent surgical review but not overnight admission.
Conclusion: The study shows that a significant proportion of acute referrals did not require immediate admission. This was particularly evident with overnight admissions. Development of clear guidelines and better access to alternate hospital referral pathways for community-based practitioners can reduce emergency admissions.

0170: SYSTEMATIC REVIEW AND META REGRESSION OF FACTORS AFFECTING MIDLINE INCISIONAL HERNIA RATES: AN ANALYSIS OF 14,618 PATIENTS

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Aim: The incidence of incisional hernias (IHs) after midline incision is difficult to define. Furthermore, recent meta-analyses give conflicting results as to the superiority of absorbable vs. non-absorbable sutures. The aim of this systematic review was to determine a pooled IH rate, and identify significant variables in predicting IH rates.
Methods: RCTs and cohort studies including patients undergoing midline incisions with no adjuncts to standard suture closure were included. Numerous paper, patient and surgical variables were extracted.
Results: From 3916 unique citations, 58 papers were used for data abstraction, detailing 83 unique groups comprising 14,618 patients. IH rates ranged from 0 to 35.6%, with a weighted mean of 12.80% at 23.7 months. Univariate regression identified numerous significant variables predicting increasing IHs. On multivariate analysis male sex, obesity surgery, AAA surgery, exclusion of patients on steroids and with existing IHs, a more recent publication year and use of a specific p value remained significant ($R^2 = 0.403$). Suture type failed to reach significance either in univariate or multivariate analysis.
Conclusion: Midline IH remains a significant clinical problem. Numerous factors can account for the large variation in published literature. Contrary to popular belief there is no evidence that suture type affects IH rates.

0202: DISCHARGE OF SURGICAL PATIENTS – A LOOK INTO CURRENT PRACTICE

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Aim: delayed discharge costs the NHS a staggering £1m/day[1]. Understanding the contributing factors is crucial to optimizing a service with limited resources. Our aim was to investigate the reasons behind delayed discharge in General Surgery inpatients. A delayed discharge was any discharge occurring after the Estimated Date of Discharge (EDD), which according to the Department of Health guidelines must be set within 24 h of admission.
Methods: we tracked the General Surgery intake at Northwick Park Hospital, London, over two weeks. Patients' EDD on admission and actual discharge date were recorded. Reasons for delays were obtained from the notes and nursing staff.
Results: only 46.3% of 97 patients had EDDs. Of these, 33.3% were discharged late. Reasons for delay were medical (53.3%), awaiting review from another team (6.7%), social/therapy (13.3%), and unknown (26.7%). Non-medical delays (40.0%) led to an additional 15 days of bed usage, projecting to £106,470 p.a. based on current bed costs[2].
Conclusion: unnecessary discharge delays are costly and reflect poor communication between care providers. Furthermore, current practice does not conform to guidelines. Therefore, we devise a simple tool to facilitate communication of patients' readiness for discharge within the multidisciplinary team, which will be implemented to close the audit cycle.

0230: INFORMED CONSENT FOR SURGERY – WHEN SHOULD THIS BE DONE?

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Aim: Research on informed consent has focused on the quantity and quality of information delivered. Very few have explored its timing. We investigated when patients preferred to receive information and give consent for surgery and also determine whether their needs were met.
Methods: All patient undergoing day-case intermediate surgery at a District General Hospital over 6 weeks completed a questionnaire detailing their experiences of the consent process and their preferences.
Results: Ninety-five patients were studied. Mean age was 50 (range 16–90) years and 50 (53%) were female. Most (44, 46%) wanted to receive information when they saw the specialist in the outpatient clinic. This was consistent with our practice (48, 51%). Others preferred to receive information at the pre-operative assessment clinic (17, 18%), on the day of surgery (16, 17%) or at the GP practice before referral (13, 14%). As to the timing of obtaining written consent, 62 (65%) preferred the day of surgery. Seventy-eight (82%) gave their consent at this time.
Conclusion: Patients preferred to receive information about their proposed surgery when they saw the specialist in the outpatient clinic and wanted to sign their consent form on the day of surgery, which was consistent with our current practice.

0244: THROUGH THE LOOKING GLASS: A SYSTEMATIC REVIEW OF INTRAOPERATIVE HEAD MOUNTED DISPLAYS

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Aim: Head Mounted Displays (HMDs) are currently used in military aviation to improve pilots' performance and could also augment surgeons' performance in the operating theatre. Accordingly, the aim of this study was to review the evidence for the intraoperative use of HMDs.
Methods: Pubmed, Medline and Ovid were searched using the terms: "Google Glass" OR "head mounted display" OR "face mounted display" OR "heads up display" AND "surgery OR surgeon". For each study we recorded the methodology, surgical speciality, HMD specification and study conclusions.
Results: Thirty one studies met the inclusion criteria. The common surgical speciality was laparoscopic surgery (ten studies). The most popular type of HMD was the non-see through configuration (seventeen studies), whilst only three studies included the Google Glass.
Conclusion: Advantages of HMDs were improved access to patient information, capability for teleassistance and intraoperative augmented reality. Opaque HMDs used in laparoscopic surgery subjectively improved ergonomics but objective performance improvement was not demonstrated. See-through HMDs used in an augmented reality configuration showed promise in open procedures however high quality studies were lacking. Authors expressed concerns regarding accuracy of intraoperative tracking, visual fidelity, weight of devices and associated operator tiredness; however newer technologies may overcome these issues.